PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS

Name of Patient_____ Medical Record #_____

Date of Birth_____ Social Security #_____
(Providing your SS# is voluntary, but not necessary to accurately identify your medical records. Failure to provide this information may delay processing your records.)

Patient Address_____
Street Address State Zip code

Phone #_____

Approximate Dates of Treatment_____
From To

1. I authorize the following health care provider or facility to **DISCLOSE** my patient information:

Name of Health Care Provider or Facility:_____
Phone # _____ Fax #_____
Address:_____
Street Address State Zip code

2. I authorize the following health care provider or facility to **RECEIVE** my patient information:

Name of Health Care Provider or Facility: COASTAL CAROLINA HEALTH CARE, P.A.
Phone # (252) 514-6685_____ Fax # (252) 633-3972_____
Address: P. O. BOX 12248, NEW BERN, NC 28561_____

3. Please disclose the following information: (Circle to indicate your selection)

History and Physical	Discharge Summary
Treatment Plans	Office Notes/Nursing Notes
Radiology and Lab Reports	Consultation Reports

4. I understand that this authorization included consent for the release of alcohol, drug, psychiatric, and psychological information; and any information relating to pregnancy, sexually transmitted disease, HIV testing, AIDS and any AIDS related syndromes. It also includes any information concerning cancer, cancer testing, and cancer results.

5. Please indicate the purpose of the disclosure of your patient records:

_____
_____
_____

6. I understand that if the authorized recipient of this information is not a health care provider or health plan covered by Federal privacy regulations and the recipient may re-disclose the information. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

7. I understand that Coastal Carolina Health Care, P.A. will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I may inspect or copy any information used or disclosed under this authorization.

8. This authorization expires: (Circle one)

1 year from the date I sign below 90 days from the date I sign below

I understand that I may revoke this authorization, except to the extent that action has already been taken, in writing at any time by sending written revocation of authorization to the releasing provider.

I hereby consent and authorize you to release copies of my medical records, including current and previous medical records from other practices and practitioners, hospitals, and/or clinics, which are a part of my medical records. I agree that a copy of this release of a fax of this release shall be valid as the original release.

_____ _____
Signature of Patient or Representative Date

_____
Patient's Name

_____
Name of Personal Representative

If signing as a Personal Representative, describe authority to act for patient and submit documentation showing such
authority:_____
_____

_____
Signature of Witness who verified identification of patient or personal representative